HUMAN VALUES, HEALTH CONCEPTS, AND TREATMENT APPROACHES ARE CULTURE-DEPENDENT: WHY WESTERN PSYCHOLOGY DOES NOT SUFFICE

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Abstract

We challenged the assumption that traditional Western psychology would possess worldwide validity. (1) We compared human values in European individualist vs. Arab and South African collectivist societies. E.g., whereas European religiosity (N = 456 Austrians) was regarded a private matter, in Arab culture (N = 737, American University, Cairo) being religious implied endorsing national Arabism and in South African, indigenous culture, for N = 400 respondents at Sovenga religiousness were intertwined with pro-social attitudes. Recently we confirmed theoretical predictions regarding differences in N = 336 Indian vs. N = 163 Central European respondents' style of moral judgment. – (2) In line with expectations, Diagnostic Criteria as set forth by DSM-IV-TR only insufficiently reflected the post-traumatic symptomatology in N = 150 refugees from Chechnya, Afghanistan, and West Africa and we found distinct differences with respect to symptomatology between these cultural groups. – (3) We tested a cultural self-help group (SHG) program for Chechen refugees in a randomized, controlled trial (N = 94). SHGs facilitated by Chechnyan laypeople were equally effective as Cognitive Behavior Therapy (CBT) and highly superior to the wait-list condition (Cohen's d = 0.93). – (4) We could not, however, replicate these findings with N = 66 female Turkish migrants with recurrent depression: neither SHG nor CBT reduced clinical symptoms. Western psychological paradigms must be replaced by culturally specific ones, but SHG only in some cases can replace treatment. Alternatively, culturally specific treatment approaches conducted by a clinical psychologist with a migration background is being studied in an Austrian psychosomatic clinic.

Keywords: Culture, Human Values, Post-traumatic symptoms, self-help

Introduction

Individualist vs. and Collectivist Values and Views of Humanity

Traditional Western psychology took for granted that universal principles would sufficiently explain human experience and behavior worldwide. Therefore, cultural differences and peculiarities were neglected by the academic mainstream. Although DSM-5 has started to take cultural differences into consideration, clinical psychology still orients by diagnostic criteria and treatment concepts developed in North America or Central Europe for White middleclass patients.

In order to investigate health related cultural differences, several years ago we have started from the theoretical concept of individualist vs. collectivist cultures and their respective value orientations. In the late 19th century, the German philosopher Tönnies (1887/2001) differentiated *Society* from *Community* , with *Society* having developed after the industrial revolution and emphasizing abstract forms of living together, whereas *Community* focused on living together in a tangible way as a member of an extended family or a small village. Similarly, Hofstede (1984) and Triandis (1995) referred to Individualism, resembling

Toennies' *Society* and to Collectivism, standing for *Community*. Although today there is a worldwide trend from Collectivism to Individualism, the Arab World, Asia, Sub-Saharan Africa and South America still orient by collectivist rather than by individualist values, putting more emphasis on collective well-being that on the individual's personal interests. Markus and Kitayama (1991) referred to the same phenomenon, by differentiating *independent* (individualist) from *interdependent* (collectivist) cultures. Similarly, Shweder's (2000) cultural psychology introduced three ethics, with the *Ethic of Autonomy* resembling individualist and the *Ethics of Community* and *Divinity* resembling collectivist values.

Along these lines, the first author examined human values in various cultures on the basis of the lexical approach. This method starts with extracting relevant concepts from the lexicon of the respective language and continues with asking several hundred participants to rate these concepts with respect to their perceived personal relevance. In central Europe, on the basis of a sample of N = 456 respondents, by Exploratory Factor Analysis (EFA), Renner (2003) found five value dimensions representing the individualist Austrian, Central European culture, namely: *(1) Personal and interpersonal harmony* (e.g., fairness, community), *(2)* Intellectualism (e.g., social criticism, reflection), *(3) Conservatism* (e.g., patriotism, tradition), *(4) Religiosity* (e.g., fear of God, faith), and *(5) Materialism* (e.g., wealth, career). In contrast, Renner and Myambo (2007), on the basis of an Arabic dictionary, established a taxonomy of Arab values and submitted it to N = 737 students of the American University in Cairo (AUC). In this case, EFA yielded six dimensions, namely *(1) Nobility and Compassion* (e.g., greeting, hospitality), *(2) Discipline* (e.g., order, patience), *(3) Advancement* (e.g., discovery, exploration), *(4) Self-Actualization* (e.g., freedom of choice, delight), *(5) Belief and Commitment* (e.g., veil, national defense), and *(6) Counter-Culture* (e.g., hostility, anarchy). Renner, Peltzer and Phaswana (2003) examined the personal values of mostly Christian Black South Africans by a lexical analysis of the language Northern Sotho, spoken in the Northern Province of the Republic of South Africa. EFA of the ratings by N = 400 respondents yielded five dimensions: *(1) Religiosity and Support* (e.g., prayer, mutual aid), *(2) Solidarity* (e.g., attachment, hospitality), *(3) Conformity and Benevolence* (e.g., honor, respect), *(4) Leadership and Achievement* (e.g., competition, wealth), and *(5) Human Enhancement* (e.g., self-control, responsibility). The value dimensions from Austrian and Arab and South African culture reflect individualism and collectivism and the three ethics of cultural psychology. Whereas Austrian values are concerned with autonomy and personal success, Arab and South African values clearly put far more emphasis on mutual support and divinity. Moreover, the three cultures have quite different concepts of religiosity. Whereas for individualist Austrians, religiosity is largely considered a "private" matter, for Arab respondents religiosity is intertwined with Arab patriotism and for South Africans, religiosity necessarily implies charity and altruism.

A recent comparison of Indian and Austrian students by Renner (2013) confirmed the expectation of Moral Foundations Theory (Haidt & Joseph, 2004; Haidt & Kesebir, 2010): A sample of N = 336 (226 female; mean age = 21.9, s = 3.1 years) collectivist participants from Southern India not only endorsed (1) values related to avoiding *Harm* to others and (2) ensuring *Fairness*, but equally endorsed (3) *Ingroup Loyalty*, (4) *Authority*, and (5) religious *Purity*. In contrast, N = 163 Central European respondents, mostly Germans and Austrians (131 female; mean age = 25.7, s = 8.4 years), only endorsed moral foundations (1) and (2), putting little or no emphasis on (3), (4) and (5). These findings are summarized in Figure 1 by the ratings on a scale ranging from 0 *(not relevant at all)* to 6 *(highly relevant).* Additional analyses revealed that the degree of westernization or globalization as measured by a questionnaire had a marked effect on the Indian respondents' style of decision making when they were confronted with moral scenarios. As shown in Figure 2, a higher degree of globalization predicted a utilitarian style of decision making, as opposed to a deontological

one. In other words, the more globalized respondents were more ready to give up their moral convictions in favor of an alleged personal benefit (e.g., betraying a personal friend in order

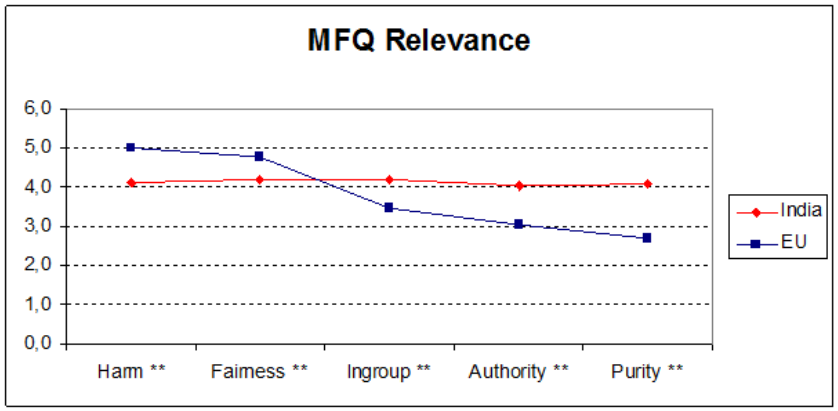

Figure 1: Results from the "Relevance" section of the Moral Foundations Questionnaire (MFQ) (Graham, Haidt & Nosek, 2009) for Indian and Austrian respondents as reported by Renner (2013).
** Differences are significant at the 1% level.

to reach one's goals more effectively). It can be seen from Figure 2 that less globalized participants rejected utilitarian decisions, as indicated by a negative score on the "Mean Utilitarian Decisions" scale, whereas the more globalized ones tended to take a more neutral, indifferent stance. Overall, our expectation of culturally specific ethics, value orientations, and views of humanity was confirmed.

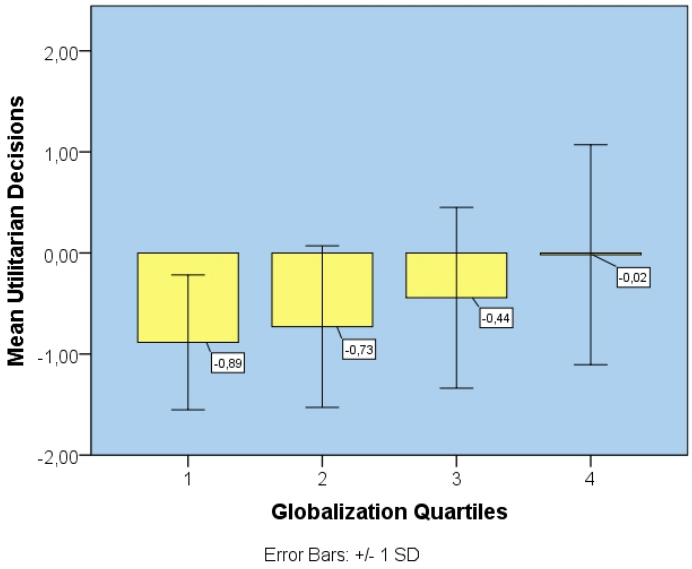

Figure 2: Globalization and utilitarian style of decision making in Indian respondents (means and standard deviations from ten moral scenarios: +2 = extremely utilitarian, -2 = least utilitarian style of decision making)

A Cross-Cultural Comparison of Clinical Symptoms in Asylum Seekers from Chechnya, Afghanistan, and West Africa

Previous research indicated that people from collectivist cultures believe in a unity of body and mind, as opposed to a typically Western dualistic point of view (de Jong, 2002; Kirmayer, 1996; Peltzer, 1995), frequently expressing mental strain by somatic symptoms (Mumford et al., 1991). Moreover, social support by their extended families is of extreme importance not only for the psychological but also for the physical well-being of people from collectivist societies. Along these lines, Eisenbruch (1991) has coined the term of "cultural bereavement" when referring to the psychological condition of refugees with a collectivist background.

In this part of our research we examined the question whether clinical symptoms, especially post-traumatic ones, would differ in patients from various parts of the world. We

started from the assumption that the typically "Western" Diagnostic Criteria of Post-Traumatic Stress Disorder (PTSD) as put forward by the then DSM-IV-TR would only partly apply to traumatized asylum seekers and refugees from Chechnya, Afghanistan and West Africa and that symptomatology would differ between these three ethnic groups as well.

A total of N = 150 asylum seekers and refugees participated. Fifty participants had come from Chechnya (N = 25 or 50% women; mean age 32.4 years, s = 10.7), N = 50 were from Afghanistan (N = 11 or 22% women; mean age 32.5 years, s = 9.0), and N = 50 participants had come from West Africa (N = 4 or 8% women; mean age 27.5 years, s = 7.1). As a criterion against which we assessed the diagnostic validity of "Western" diagnostic methods, we used clinical interviews in which we assessed possible symptoms of traumatization as well traumatic events that may have triggered symptomatology. Diagnoses of PTSD were established by the Clinician Administered PTSD Scale (CAPS-1) (Blake et al., 2000). In addition, a number of psychometric scales, measuring different facets of post-traumatic symptomatology were used:

(1) the Hopkins Symptom Checklist-25 (HSCL-25; Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987),

(2) the Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992),

(3) the Impact of Event Scale (IES-R; Weiss & Marmar, 1997),

(4) the Bradford Somatic Inventory (BSI; Mumford et al., 1991), and

(5) the Social Adaptation Self-Evaluation Scale (SASS; Bosc, Dubini, & Polin, 1997).

In a first step, the cross-cultural validity of PTSD diagnoses as assessed by the CAPS was examined. The results are summarized in Table 1. It can be seen that PTSD diagnoses yielded high numbers of False Negative cases when validated against the clinical interviews. For example, out of 31 Chechens, diagnosed positively for post-traumatic symptoms in the clinical interviews, only 15 were recognized correctly by PTSD diagnoses. Similar findings were obtained for the remaining two ethnic groups.

	PTSD positive	PTSD negative	Total
Chechnya (N = 50)			
Interview positive	15	16	31
Interview negative	0	19	19
Afghanistan (N = 50)			
Interview positive	5	17	22
Interview negative	1	27	28
West Africa (N = 50)			
Interview positive	22	12	24
Interview negative	5	21	26

Table 1: Cross-cultural validity of the Clinician Administered PTSD Scale (CAPS-1) (Blake et al., 2000), determined by diagnostic interviews as a criterion (False Positives and False Negatives in bold print)

As a next step, Renner, Salem and Ottomeyer (2007) examined whether the questionnaire scores would differentiate between the three cultures. Whereas at the level of total scores, little differences were found, discriminant analyses at the item level classified 92% of participants correctly by two discriminant functions:

Function 1 discriminated Afghans and West Africans (feeling "tense" and "on guard", accompanied by somatic symptoms) from Chechens (complaining from difficulties concentrating and feeling "detached") and

Function 2 discriminated West Africans (avoidant behavior, feelings of guilt and lack of affect) from Afghans (feeling tired, restless, or weak).

Culturally sensitive interventions as compared to traditional psychotherapy

In this third step of the research we tried to apply our findings to supporting traumatized refugees and asylum seekers in Austria as well as working migrants suffering from recurrent depression. Our findings were in line with the propositions for example by de

Jong (2004), who argued in favor of "culturally congruent" (p. 171) interventions, which should take into account different backgrounds (Eisenbruch, 1992; Kirmayer, 1989), ethnic identities and practices (Jablensky et al., 1994) as well as culturally specific symptoms (Chakraborty, 1991).

Starting from the assumption that culturally competent compatriots would not be available as experts from clinical psychology and psychiatry we resorted to self-help groups as an alternative. From the literature, there was ample evidence that self-help would be a powerful tool enabling participants to cope with post-traumatic symptomology effectively. This has been found for example by early studies conducted by the Swiss psychologist Perren-Klingler (2001) with victims of the Yugoslav war and has been later been confirmed for example by Eisenbruch, de Jong and van de Put (2004) on a global scale on behalf of the Transcultural Psychosocial Organization (TPO). Still, systematic randomized controlled longitudinal studies with regard to the effects of self-help on traumatized refugees were missing.

Chechen Refugees and Asylum Seekers

We therefore offered in a randomized controlled study

15 sessions of weekly guided self-help groups (90 minutes each in Chechen),

15 sessions of weekly group based Cognitive Behavior Therapy (CBT) (90 minutes each, interpreter-assisted in German),

a wait-list control condition (with participants receiving the self-help program after waiting time had been completed), and

three sessions of individual Eye Movement and Desensitization and Reprocessing (EMDR) (45 minutes each, interpreter-assisted in German),)

to a total of N = 94 Chechen asylum seekers and refugees in Austria (44 or 46.1% of them female) with a mean age of 34.83 years (s = 9.78).

Self-help groups were facilitated by same-sex laypeople from Chechnya in their mother tongue. They had been trained for their task in a series of workshops, teaching them basic skills of group dynamics as well as some essential knowledge of psychological trauma and post-traumatic reactions. They received neither a manual nor other written instructions on how to facilitate the groups, but were encouraged to arrange the group sessions according to their personal ideas and conceptions. Behavior therapy groups were conducted by a licensed supervisor of behavior therapy and EMDR was applied by a clinical psychologist and EMDR practitioner.

The following questionnaires were used in order to evaluate the outcome of the interventions at pre-, post-, three-months, and six-months follow-up occasions:

The Harvard Trauma Questionnaire (HTQ, Mollica et al., 1992) (items 1 to 16, which had been found to differentiate well between traumatized and healthy participants from Chechnya in our previous study),

The Hopkins Symptom Checklist (HSCL-25, Mollica et al., 1987), in order to assess additional symptomatology (anxiety, depression, somatoform symptoms), apart from post-traumatic stress,

Posttraumatic Growth Inventory (PGI, Tedeschi & Calhoun, 1996), in order to assess the participants' potential of activating personal resources as a consequence of traumatic experiences.

Both, guided self-help groups (SHG) and CBT groups proved effective only for participants with considerable symptoms of traumatization, of whom a total of N = 32 were present both, immediately before (T1) and after (T2) the interventions (SHG; N = 9; CBT: N = 10; EMDR = 6; WL = 7, men and women taken together). Considerable traumatization was defined by an HTQ score > 1.75. For these participants, according to the results of Repeated Measures ANOVA, SHG had significantly better effects than wait-list (WL) (p = .002). Effect

sizes for SHG, as compared to WL were d = 0.94. Similarly, for the HSCL-25, SHG was significantly superior to WL (p = .016) and in this case, the effect size for SHG as compared to WL was d = 0.93. On both measures, SHG proved to be equally effective as CBT, whereas EMDR showed no significant effect. Figure 3 exemplifies these results for the improvements as measured on the HTQ before and after the interventions. For none of the groups there were significant effects on the Posttraumatic Growth Inventory (PGI).

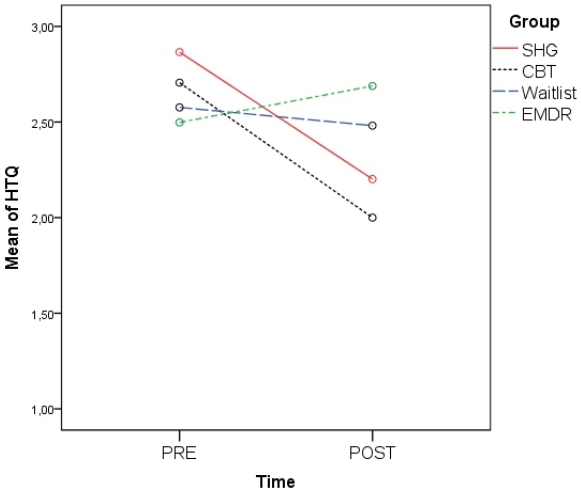

Figure 3: Change of post-traumatic symptoms on the Harvard Trauma Questionnaire (HTQ) in a total of N = 53 participants with considerable symptoms of traumatization (HTQ > 1.75)

From Figure 3 it is evident that SHG were equally effective as CBT, whereas WL and EMDR were of no avail. At the two follow-up occasions, three and six months after ending the interventions, there was no significant change of symptomatology, i.e., the effects had proven to remain stable over time (for details see Renner, Bänninger-Huber & Peltzer, 2011).

In line with the literature on the effects of culturally effective lay interventions we found that they were equally effective as professional psychotherapy. In other words, the "unspecific" effects of ethnic social support has effectively compensated for the fact that the self-help groups' facilitators were lay people without any psychotherapeutic qualification.

Turkish Working Migrants

Encouraged by the positive effects on Chechen refugees and asylum seekers, we tested the self-help approach with female working migrants from Turkey with recurrent depression. Recurrent depression is known to be a common phenomenon especially among women of Turkish descent in Austria (e.g., Cicek, 1990). It is also well documented that these diseases are commonly difficult to treat and in many cases resistant to conventional therapy. In the sense of Berry (2007), Turkish migrants in Austria use to resort to a separation rather than an integration strategy in the course of their acculturation, i.e, they rather stay among their ethnic group during their leisure time, only have poor knowledge of German, and hardly entertain social contacts with the Austrian population (Sahin, 2006).

We therefore expected that ethnic peer support would be equally beneficial for Turkish migrant women as formally for Chechen refugees and asylum seekers. The sample originally consisted of N = 66 women with a Turkish migration background, with N = 62 of them stemming from the first and N = 4 from the second generation of migration. The participants' mean age was 42.7 years (s = 8.7 years). Out of this sample, N = 21 were randomized to two guided SHGs in Turkish, N = 23 to two CBT groups conducted by an Austrian female behavior therapist assisted by an interpreter and N = 22 were randomized the the WL control condition. Both, SHG and CBT group sessions took place in weekly intervals over a 15 weeks period, each session lasting for 90 minutes.

The following questionnaire measures (all of them in their Turkish translations) were used in order to assess symptom change:

The Center for Epidemiologic Studies Depression Scale (CES-D, Radloff, 1977),
The Hopkins Symptom Checklist (HSCL-25, Mollica et al., 1987),
The Posttraumatic Growth Inventory (PGI, Tedeschi & Calhoun, 1996),
The Brief Symptom Inventory (BSI, Derogatis, 1993).
The List of Complaints (Beschwerdeliste, Schwab & Tercanli, 1987),
The Harvard Trauma Questionnaire (HTQ, Mollica et al., 1992) and
The Patient Health Questionnaire (PHQ, Özer, 2004).

In this case, neither the guided self-help intervention nor group based cognitive behavior therapy yielded significant reduction of symptoms as compared to WL on any of the scales just mentioned (for details, see Renner & Berry, 2011). In spite of the negative result on the symptom level, participants reported subjective gain with respect to their well-being as assessed by qualitative interviews (Siller & Renner, submitted). The negative findings are in line with similar results for example by Lampe and Barbist (2010), who had found negative results with group psychotherapy with Turkish migrants. From the qualitative interviews, it became clear that many participants did not accept the "self-help" nature of the intervention and rather had expected professional help. Moreover, the group leaders, who were young women without children of their own, were not recognized as distinguished "experts" especially by the older, more conservative group members. As reported by Renner and Berry (2011) in detail, younger women with a comparatively longer stay in Austria (who can be expected to have less conservative attitudes) had benefitted more from the intervention than older women or participants with a short period of stay in Austria.

Conclusion

First, our finding of value orientations differing between cultures has challenged the traditional view of "Western" psychology claiming universal validity over many decades. Moreover, the main assumption of this research program of health related concepts being intertwined with the cultural specificities of individualist and collectivist societies has been confirmed. In the first place, our results have shown that clinical symptomatology differs between cultures and that these cultural differences must be dealt with in the course of therapy. The results have also shown that ethnic support may have a substantial impact on the reduction of clinical symptoms especially in refugees and asylum seekers suffering from symptoms of post-traumatic stress. Our results obtained from female Turkish migrant women, however, suggest that for this group of patients, lay-help does not suffice for them. In contrast, clinical psychologists and/or psychiatrists who share the patients' ethnic background should be engaged in order to provide interventions which take cultural specificities into account. In this respect, a pilot study at an Austrian clinic has recently been conducted and we have the honor to report its results in our second contribution to this conference (Salem, Gaugeler & Renner, submitted). Overall, our results suggest that a solely "Western" approach to psychology is overly simplistic and cultural aspects of diagnostic assessments and therapy should receive more attention.

Limitations of this research program pertain to the fact that to date we have ascertained that cultural differences must be dealt with in clinical psychology, but we are not yet able to determine in detail, *which* cultural differences exist *to what extent,* and, more importantly from a humanitarian point of view, *which ethnic groups* need exactly *which type of interventions.* These limitations set the goals for future research.

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